WALK-IN PRESCRIPTION/SAMPLE REQUEST FORM

Please complete entire form. Allow ***at least 72 hours*** for all requests. If form is not completed, your request ***will not*** be processed.

Patient's Full Name: ____ DOB: _______________

Home Phone #: (_____)________________ Cell/Work Phone #: (_____)___________________

Circle the name of your provider:

Bivens **Koch** **Bailey** **Mulinda** **Myers**

Please mark one of the following:

______ I will pick up this request, only after being notified that it is ready.

______ Please call this request in to my pharmacy.

Pharmacy Name: ____

Location of Pharmacy: ____

Pharmacy Phone Number #: (_____) _____________________________

______ Please mail this request to the following address:

____

____

____

Medication(s) requested:

MEDICATION NAME	STRENGTH	FREQUENCY TAKEN

Please indicate the duration for which you would like your prescription filled:

30 Day **60 Day** **90 Day**